DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45th 5/15/12

PRINTED: 03/29/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445498	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	03/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRISTOL NURSING HOME	261 NORTH STREET BRISTOL, TN 37625

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 015 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Interior finish for rooms and spaces not used for corridors or exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings, has a flame spread rating of Class A or Class B. (In fully sprinklered buildings, flame spread rating of Class A, Class B, or Class C may be continued in use within rooms separated in accordance with 19.3.6 from the access corridors.) 19.3.3.1, 19.3.3.2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure interior surface finishes had a flame spread rating of C or less. The findings include: Observation and interview with the Maintenance Director in the front reception area, on March 26, 2012 at 9:35 a.m. confirmed the walls in the front reception office was wood paneling and no flame spread documentation was available to show it was class "A", "B" or "C". This finding was verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on March 26, 2012.	K 015	K015 No residents were affected. Walls in the reception area will be painted with a fire retardant paint. Paint information will be added to the next Quality Assurance committee (Administrator, Director of Nursing, Assistant Director of Nursing, Medical Director, Business Office manager, Dietary Manager, Activities Director, Social Services Director, and Therapy Manager) meeting minutes and a copy will be kept on file in the Maintenance office.	
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only	K 018	completion Date: 5/11/12	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Christopher A. Gaddy
TITLE: Administrator
(X6) DATE: 4/20/12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 018	Continued From page 1 required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure corridor doors would close to a positive latch. The findings include: Observation and interview with the Maintenance Director on March 26, 2012 at 10:35 a.m. confirmed the soiled linen room door by 221, room 202, 111, 1st floor staff lounge door, and door to housekeeping failed to close to a positive latch. Observation on March 26, 2012 at 10:30 a.m. confirmed the kitchen door near the conference room was held open by rubbing on the floor and was not self-closing. These findings were verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on March 26, 2012.	K 018	K018 No residents were affected. An audit of all self-closing doors will be performed to ensure closure. All doors found not to be latching to positive latch will be corrected. The Maintenance director will do checks monthly of random doors with self- closures to ensure latch and the monthly checks will be monitored in the Quality Assurance Committee meeting on a quarterly basis. The Quality Assurance committee (Administrator, Director of nursing, Assistant Director of Nursing, Medical Director, Business Office Manager, Dietary Manager, Activities Director, Social Services, and Therapy Manager) will make recommendations to revise or improve the process and determine when compliance has been achieved.	completion Date 5/11/12
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD	K 029		

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K 029	Continued From page 2 One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure hazardous areas fire ratings were maintained. The findings include: Observation and interview with the Maintenance Director on March 26, 2012 between 10:30 a.m. and 2:30 p.m. confirmed the following: 1) The outside Oxygen storage room had 3 unsealed conduit penetrations in the wall. 2) The elevator equipment room door in the basement was an unrated, louvered wooden door. 3) The Basement boiler room and medical records storage room ceilings had greater than 150 sqft lath and plaster removed for the repair of water leaks. These findings were verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on March 26, 2012.	K 029	No residents were affected. Penetrations in the wall in the outside oxygen storage room will be filled. Elevator equipment room door will be replaced. Ceilings in basement boiler room and medical records storage room will be fixed. Checks for penetrations will be added to the monthly preventive maintenance rounds. The checks will be monitored in the Quality Assurance Committee meeting on a quarterly basis for one year. The Quality Assurance committee (Administrator, Director of nursing, Assistant Director of Nursing, Medical Director, Business Office Manager, Dietary Manager, Activities Director, Social Services, and Therapy Manager) will make recommendations to revise or improve the process and determine when compliance has been achieved.	completion Date 5/11/12
K 038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD	K 038		

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K 038	Continued From page 3 Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure delayed-egress door locks were provided with instructive signage and would operate in accordance with NFPA 101, Sec. 7.2.1.6.1. Findings include: Observation and interview with the Maintenance Director, on March 26, 2012 at 10:50 a.m. confirmed 1 of 3 exit doors on the second floor, by room 214, had delayed-egress magnetic locking hardware and was not provided with a sign reading, PUSH UNTIL ALARM SOUNDS - DOOR CAN BE OPENED IN 15 SECONDS. Observation and interview with the Maintenance Director, on March 26, 2012 at 11:30 a.m. confirmed 1 of 3 delayed-egress exit doors next to the elevator on the second floor failed to open in 15-seconds when tested. These findings were verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on March 26, 2012.	K 038	All resident on 2nd Tennessee had the potential to be affected. Maintenance will check all delayed egress exit doors on the second floor for proper release time. Any door found out of compliance will be fixed. The Maintenance Director will make checks weekly of delayed egress doors to check for appropriate release time and the checks will be monitored in the Quality Assurance Committee meeting on a monthly basis. The Quality Assurance committee (Administrator, Director of nursing, Assistant Director of Nursing, Medical Director, Business Office Manager, Dietary Manager, Activities Director, Social Services, and Therapy Manager) will make recommendations to revise or improve the process and determine when compliance has been achieved.	
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is	K 050		Completion Date 5/11/12

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K 050	Continued From page 4 assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure fire drills were conducted quarterly at varying times on each shift and that staff was familiar with fire drill procedures. (NFPA 101, 19.7.2) The findings include: Record review with the Maintenance Director on March 26, 2012 at 9:10 a.m. confirmed fire drills had not been performed on any shift for the 2nd quarter of 2011 and 2nd shift fire drills times were not varied with them being conducted on at 7:30 pm on September 28 and December 14, 2011. Observation during a fire drill, with the Maintenance Director, initiated on March 26, 2012 at 11:22 a.m. confirmed the person discovering the fire and four (4) additional staff failed to call out the required code phrase until 11:26 a.m., five (5) staff failed to close the door to the resident's room until prompted by the Surveyor at 11:28 a.m., and failed to activate the building fire alarm for 8 minutes, until prompted by the Surveyor at 11:30 a.m.. Observation during the fire drill on March 26, 2012 at 11:32 a.m. revealed Staff failed to ensure doors to resident rooms 203 and 215 were closed to a positive latch. Observation during the fire drill on March 26, 2012 at 11:33 a.m. revealed Staff failed to remove twenty residents who were left sitting in	K 050	K050 All residents had the potential to be affected. All employees will be in serviced on the fire drill procedure. Fire drills will be carried out at random times at least quarterly on each shift. Any fire drills performed will be brought to the Administrator for signature. Fire drills will be reported to the Quality Assurance committee by the maintenance director on a quarterly basis. The Quality Assurance committee (Administrator, Director of nursing, Assistant Director of Nursing, Medical Director, Business Office Manager, Dietary Manager, Activities Director, Social Services, and Therapy Manager) will make recommendations to revise or improve the process and determine when compliance has been achieved.	Completion Date: 5/11/12

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K 050	Continued From page 5 the second floor activity room that was open to the corridor across from the Nurses station in the same smoke compartment as the fire. These findings were verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on March 26, 2012.	K 050	K056 No residents were affected.	
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: NFPA 13, 5-13.6.1 Sidewall spray sprinklers shall be installed at the bottom of each elevator hoistway not more than 2 ft (0.61 m) above the floor of the pit. NFPA 13, 5-13.6.3 Upright or pendent spray sprinklers shall be installed at the top of elevator hoistways. Based on observation, interview, and record review, the facility failed to assure all areas were sprinkled.	K 056	Vendor has been obtained to complete needed sprinkler work. Elevator inspection reports will be brought to the Quality Assurance committee to monitor for ongoing compliance.	Completion Date 5/11/12

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K 056	Continued From page 6 The findings include: Observation and interview with the Maintenance Director on March 26, 2012 at 1:30 p.m. confirmed the top and bottom of the elevator shaft and one side of the 1st floor biohazard room was not sprinkled. Record review of building sprinkler system working drawings with the Maintenance Director on March 26, 2012 at 2:30 p.m. confirmed sprinkler heads were not provided in the elevator shaft. These findings were verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on March 26, 2012.	K 056	K066 No residents were affected. Metal containers with self-closing cover devices were ordered on 4/17/2012 and will be placed when received.	
K 066 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is	K 066	The Maintenance Director will make checks weekly to ensure containers are in place. The checks will be monitored in the Quality Assurance Committee meeting on a quarterly basis. The Quality Assurance committee (Administrator, Director of nursing, Assistant Director of Nursing, Medical Director, Business Office Manager, Dietary Manager, Activities Director, Social Services, and Therapy Manager) will make recommendations to revise or improve the process and determine when compliance has been achieved.	Completion Date 5/11/12

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K 066	Continued From page 7 permitted. 19.7.4 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure smoking areas were provided with metal containers with self-closing cover devices (NFPA 101, 19.7.4 (4)). The findings include: Observation and interview with the Maintenance Director, on March 26, 2012 at 10:40 a.m. confirmed the outside smoking area had an open trash receptacle. This finding was verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on March 26, 2012.	K 066	K069 No residents were affected. Record review showed the kitchen hood suppression inspections were conducted on 2/26/12, 8/15/2011, and 2/13/2011. Grease trays will be installed on the kitchen hood. Openings in the hood will be sealed on the sides of the filter plenum. The deep fryer will be moved to a minimum of 16 inches from the stove top and a higher splatter guard will be placed.	
K 069 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: NFPA 96, 8-2 An inspection and servicing of the fire-extinguishing system and listed exhaust hoods containing a constant or fire-actuated water system shall be made at least every 6 months by properly trained and qualified persons. Based on record review and interview, the facility failed to assure commercial cooking equipment is inspected semi-annually and complies with NFPA 96. The findings include: Record review with the Maintenance Director, on	K 069	Quarterly inspection reports will be brought to the Quality Assurance committee on a quarterly basis and any issues will be addressed. The Quality Assurance committee (Administrator, Director of nursing, Assistant Director of Nursing, Medical Director, Business Office Manager, Dietary Manager, Activities Director, Social Services, and Therapy Manager) will make recommendations to revise or improve the process and determine when compliance has been achieved.	Completion Date 5/11/12

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K 069	Continued From page 8 March 26, 2012 at 8:45 a.m. confirmed the Kitchen hood fire suppression system was not inspected semi-annually. Inspection reports were dates 2-10-2011 and 2-10-2012. NFPA 96, 3-2.6 Filters shall be equipped with a drip tray beneath their lower edges. The tray shall be kept to the minimum size needed to collect grease and shall be pitched to drain into an enclosed metal container having a capacity not exceeding 1 gal (3.785 L). Based on observation and interview, the facility failed to assure commercial cooking equipment complies with NFPA 96. The findings include: Observation and interview with the Maintenance Director, on March 26, 2012 at 8:45 a.m. confirmed kitchen hood was not provided with an enclosed metal container to catch grease and had several openings that were not sealed on the sides of the filter plenum. Observation and interview with the Maintenance Director in the kitchen, on March 26, 2012 at 10:15 a.m. confirmed the deep fryer was not located a minimum of 16-inches from the stovetop and was centered below its suppression system nozzle.(NFPA 96, 9-1.2.3). These findings were verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on March 26, 2012.	K 069		
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by:	K 147		

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K 147	Continued From page 9 Based on observation and interview, the facility failed to assure electrical outlets were maintained. The findings include: Observation and interview with the Maintenance Director, on March 26, 2012 at 10:40 a.m. confirmed two (2) electrical receptacles, located next to the walk-in cooler and behind the deep fryer, were heat discolored, suggesting overheating of the wall receptacles (NFPA 70). This finding was verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on March 26, 2012.	K 147	K147 No residents were affected. An audit of all electrical outlets in the kitchen will be done. Any out of compliance will be changed. Visual checks of electrical outlets will be done by the dietary supervisor and any problems reported to maintenance. Any issues with electrical outlets in the kitchen will be brought to the Quality Assurance Committee meeting for monitoring and compliance. The Quality Assurance committee (Administrator, Director of nursing, Assistant Director of Nursing, Medical Director, Business Office Manager, Dietary Manager, Activities Director, Social Services, and Therapy Manager) will make recommendations to revise or improve the process and determine when compliance has been achieved.	completion date 5/11/12